

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095		X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		X3) DATE SURVEY COMPLETED 03/10/2011	
NAME OF PROVIDER OR SUPPLIER HERITAGE PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON ROAD FORT WAYNE, IN46805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/10/11</p> <p>Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Heritage Park was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and all resident rooms on 200 hall. The facility has a capacity of 180 and had a census of</p>		K0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2011

FORM APPROVED

OMB NO. 0938-0391

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	168 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/15/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by						

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K0029 SS=E	<p>1. Based on observation and interview, the facility failed to ensure 1 of 1 roll down doors at the openings in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect any residents in the main hall dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping/Laundry Supervisor on 03/10/11 at 11:50 a.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore, considered to be the corridor wall. There was a pass through opening in the corridor wall between the dining room and the kitchen. The opening was protected with a rolling fire door with a fusible link. Based on interview with Maintenance Director at the time of observation, the rolling fire door does not close upon activation of the fire alarm.</p> <p>3.1-19(b)</p> <p>2. Based on observation and</p>		K0029	<p>What corrective action(s) will be accomplished for the those residents found to have been affected by the deficient practice?-No residents were found to have been affected by the alleged deficient practice.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?-All residents in the main dining room and 300/500 halls had the potential to be affected by the alleged deficient practice.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur:-Rolling window into dietary will be replaced by a window that automatically closes when the fire alarm is tripped. -Swining door into dietary will be replaced by a smoke resistive door.How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur: -Executive Director and Governing CQI will review and approve any future remodeling that could involve smoke resistive doors or changes to the dietary window.</p>		04/08/2011	

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	<p>interview, the facility failed to ensure 1 of 1 kitchen doors in the main dining room protecting corridor openings was smoke resistive. This deficient practice could affect any residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping/Laundry Supervisor on 03/10/11 at 1:00 p.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore, considered to be the corridor wall. The kitchen door had a one half inch gap on both sides and a three fourths inch gap at the top of the door. Additionally, the door was a swinging type door that did not latch into the door frame. Measurements were provided by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>						

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K0056 SS=E	<p>Based on observation and interview, the facility failed to ensure four rooms in 2 of 13 smoke compartments were equipped with one type of sprinkler head, i.e., quick response sprinklers or standard sprinklers. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect all residents in the main dining room and at the 300/500 nurses' station.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Housekeeping/Laundry Supervisor on 03/10/11 between 12:00 p.m. and 12:15 p.m. the main dining room area and the 300/500 nurses' station area had a mixture of quick response sprinkler heads and standard response sprinkler heads. This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p>			K0056	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:-No residents were found to have been affected by the alleged deficient practice.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:-All residents in the main dining room and 300/500 hall had the potential to be affected.-All identified sprinkler heads will be replaced.What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur: -Maintenance Director has a documented list of sprinkler heads and types in use in the building.How the corrective action(s) will be monitored to ensure the deficient practice does not reoccur:-Executive Director will sign off on every future contract for sprinkler changes to verify that sprinkler heads are consistent with what is currently in place.</p>		04/08/2011

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K0144 SS=F	<p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping/Laundry Supervisor on 03/10/11 during a tour of the facility from 10:25 a.m. to 2:15 p.m., the facility did not have a remote manual</p>		K0144	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:-No residents were found to have been affected by the alleged deficient practice.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:-All residents residing in the facility had the potential to be affected.-A remote manual stop for the emergency generator will be installed.-A letter from Nipsco will be obtained that includes the supporting statements of reliability of natural gas, low probability of interruption of the natural gas and a signature of a technical person. What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not reoccur:-Executive Director will approve any change to the current generator.-Executive Director will seek an annual update to Nipsco letter.How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur:-Governing CQI will approve any changes to generator and review Nipsco letter annually.</p>		04/08/2011	

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	<p>stop for the emergency generator. Based on an interview with the Maintenance Director at 2:15 a.m., the generator motor was at least 260 horsepower.</p> <p>3-1.19(b)</p> <p>2. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid petroleum products at atmospheric pressure</p> <p>b) Liquified petroleum gas (liquid or vapor withdrawal)</p> <p>c) Natural or synthetic gas</p> <p>Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be</p>						

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	<p>delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the Maintenance Director on 03/10/11 at 10:25 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider</p>						

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	(NIPSCO) dated November 20, 2008 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas, low probability of interruption of the natural gas service and a signature of a technical person. This was acknowledged by the Maintenance Director during the time of record review. 3.1-19(b)						